

KENYA NATIONAL HEALTH ARCHITECTURE

HEALTH INSURANCE

The Financial Architecture

Problem diagnosis, design preconditions, and a brief for specialist financial architecture. The system that pays for the system.

Addendum to the Kenya Health Vision · 2026

THE PROBLEM IN FULL

Kenya has a health system that can be physically present and economically absent simultaneously. A functioning ambulance network can deliver a patient to a Level 3 sub-county hospital in forty minutes. The bill that follows that visit can destroy the family financially. Physical access without financial access is not universal health coverage. It is universal access to bankruptcy.

The insurance architecture is not a separate problem from the health system architecture. It is the same problem seen from the payment side. Every failure in the insurance system is amplified by a failure in the facility system, and vice versa.

The Five Failures

FAILURE	WHAT IT MEANS IN PRACTICE
1. The Coverage Gap	Millions of Kenyans have no insurance at all and pay out of pocket at the worst possible moment — when they are sick, vulnerable, and have no negotiating power. Out-of-pocket health expenditure is the leading driver of household poverty in Kenya.
2. NHIF Failure	The National Hospital Insurance Fund became a corruption vehicle with selective coverage, delayed reimbursements that destroyed facility cash flow, and political interference in governance. It collected premiums and created obligations it could not honour. Its replacement — the Social Health Insurance Fund — has not yet resolved the structural problems that caused NHIF to fail.
3. Predatory Private Insurance	Private insurers operate predatorily because the market structure allows it. When there is one oncology machine in a region, the insurer knows the patient has no choice and prices accordingly. When facilities are unaccountable, insurers and facilities collude to inflate bills. Predation is a consequence of market structure, not just insurer ethics.
4. The Informal Sector Problem	Most Kenyans work informally. Employer-linked insurance models, copied from European welfare states with formal employment as the norm, do not reach them. The people most exposed to financial catastrophe from health costs are the least likely to be insured under any model built around formal employment.
5. The Actuarial Vacuum	Every previous attempt at national health insurance in Kenya has been priced and designed in a vacuum — without a standardised facility cost structure, without predictable referral routing, and without population health data. You cannot price a risk you cannot define. Without the health architecture, the insurance architecture is guesswork.

THE PRINCIPLE

A health system that works for the sick but bankrupts the patient has not solved the problem. Universal health coverage means the full clinical encounter — from the Community Health Paramedic at the door to the specialist at Level 5 — is financially accessible to every Kenyan without the cost of that access destroying the household. This is not idealism. It is the condition under which the health architecture generates the social return it was built to generate.

WHAT THE HEALTH ARCHITECTURE MAKES POSSIBLE

For the first time, the elements required for a properly designed national health insurance scheme exist:

PRECONDITION	HOW THE ARCHITECTURE PROVIDES IT
Defined cost at every level	The Level Specification Document defines the exact staffing, equipment, and service capability at every level. Costs are predictable and comparable nationally, not facility-by-facility guesses.
Predictable referral routing	The Ambulance Corps enforces routing to the correct level. The insurer knows what percentage of cases go to L1, L2, L3, L4, L5. Actuarial modelling becomes possible.
Population health data	4,400 Community Health Paramedics collecting household surveillance data nationally. Real epidemiological intelligence — disease burden, at-risk populations, geographic distribution — for the first time.
Defined hard-to-reach population	16,000 Clan Health Wardens and the nomadic programme define and locate the previously invisible population. Actuaries can model the nomadic population's risk profile rather than excluding them.
No-charge emergency entry point	The Ambulance Corps Act mandates no charge at point of use for emergency services. The insurance scheme does not need to cover emergency dispatch — it picks up from facility arrival.

THE DESIGN BRIEF FOR SPECIALIST ARCHITECTS

The detailed financial architecture of the national health insurance scheme requires specialist expertise in health economics, actuarial science, and public finance that is beyond the scope of this document. What follows is the brief that specialist architects should work from.

Non-Negotiable Principles

1. Universal coverage — every Kenyan is covered from birth. No opt-out, no exclusion by employment status, income, geography, or pre-existing condition.
2. No catastrophic expenditure — no Kenyan household pays more than a defined percentage of annual income on health costs in any twelve-month period. The scheme absorbs the catastrophic tail.
3. The informal sector is the design case, not an exception — the scheme is built around informal workers and extended to formal employees, not the reverse.
4. Progressive contribution — contributions are scaled to income. The poorest Kenyans contribute the least or nothing. The scheme is redistributive.
5. No charge at point of use for emergency services — consistent with the Ambulance Corps Act.
6. Facility payment is cost-based, not fee-for-service — facilities are reimbursed against the Level Specification cost standard, not against whatever they choose to bill. This removes the incentive for bill inflation.

Known Failure Modes to Avoid

- NHIF's failure mode: collecting premiums without building reserves sufficient to honour obligations. The scheme must be actuarially solvent from inception.
- Political governance failure: NHIF's board was subject to political interference. The insurance institution must have the same governance protections as the Ambulance Corps — fixed-term leadership, parliamentary confirmation, protected appropriation.
- Voluntary scheme failure: voluntary schemes suffer adverse selection — only sick people join. The scheme must be mandatory and universal.
- Employer-linkage failure: employer-linked contributions exclude the informal sector. Contribution collection must be decoupled from formal employment.
- Fee-for-service failure: fee-for-service creates incentives for over-treatment and bill inflation. The Level Specification cost standard is the payment ceiling, not the facility's invoice.

Open Questions for Specialist Resolution

7. Contribution mechanism for informal workers — how are premiums collected from a population without regular formal income? Mobile money integration is the obvious answer but the precise mechanism requires specialist design.
8. Risk pooling architecture — single national pool, county pools, or a hybrid? Single pool provides the broadest risk distribution. County pools create accountability but may produce adverse selection in high-risk counties.
9. Benefit package definition — what is covered at each level and what is not? The Level Specification sets the service capability. The insurance benefit package must align with it precisely.
10. Subsidy architecture — how are contributions for the poorest Kenyans funded? Direct Treasury subsidy, cross-subsidy from higher earners, or a combination? The fiscal modelling requires specialist input.
11. Transition from SHIF — the Social Health Insurance Fund is operational. How is the new architecture introduced without destroying the coverage that currently exists, imperfect as it is?

A note on sequencing: the insurance reform and the health architecture reform are mutually reinforcing but not mutually dependent. The ambulance network can be built and made operational before the insurance architecture is finalised. The Level Specification can be written and facility upgrading begun before the insurance scheme is designed. The preconditions the insurance needs are being created by the health architecture work. The insurance design should begin in parallel, drawing on the architecture as it develops, and should reach legislative readiness at approximately the same time the Level 3 sub-county hospital network reaches operational standard — so that the insurance scheme and the functioning referral hierarchy launch together.

THE DOCTRINE

***The system that saves your life
must not be the system that ruins it.***

*Universal coverage is not generosity.
It is the condition under which everything else works.*

Afya kwa Wakenya Wote